Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

MEMORIAL THERAPEUTIC PRODUCTS
8200 WEDNESBURY #475
HOUSTON TX 77074

Respondent Name
ACE AMERICAN INSURANCE CO

Carrier's Austin Representative Box
Box Number 15

MFDR Tracking Number
M4-11-4970-01

MFDR Date Received
AUGUST 29, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "If Cypress Care is not responsible for payment on this claim then why have they issued payment on this patient before on multiple dates of service. As for the supplies not being authorized, Please refer to the Texas Department of Insurances pre-authorization guidelines, specifically Rule 134.6 [sic]… We resubmitted on 03/10/11 with the above mentioned information for all dates of service. We spoke to Cypress Care and they told us that we needed to forward these claims to Broadspire insurance company, I explained that they have issued payment on this patients claim before but was told there was nothing they could do. I did forward the claims to Broadspire insurance company but since we were not within the 95 days to bill they were denied."

Amount in Dispute: $134.88

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The evidence clearly demonstrates that the bill was not timely filed with the Insurance Carrier. The first receipt by the Carrier was April 26, 2011. (see attached evidence of receipt) This date is clearly outside the 95 day filing timeframe. Cypress Care, Inc. is neither the Insurance Carrier nor their Third Party Administrator for this employer. Cypress Care, Inc. is not an Insurance Carrier or Third Party Administrator at all. Cypress Care, Inc. is a DME vendor. Accordingly no timeline recalculation applies."

Response Submitted by: Pappas & Suchma, PC, PO Box 66655, Austin, TX 78766

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 5, 2010	DME TENS Unit Supplies	$134.88	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical

fee dispute.

2. 28 Texas Administrative Code §133.20 sets out the procedures for health care providers to submit workers' compensation medical bills for reimbursement.
3. 28 Texas Administrative Code §102.4 sets out the rules for non-Commission communications.
4. Texas Labor Code §408.027 sets out the rules for timely submission of a claim by a health care provider.
5. Texas Labor Code §408.0272 sets out the rules for certain exceptions for untimely submission of a claim by a health care provider.
6. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - B4 – Late filing penalty.
   - 669-022 – Based on fee schedule guidelines, bills submitted after the 95th day after the date of service are disallowed.

Issues

1. Is the timely filing deadline applicable to the medical bills for the services in dispute?
2. Did the requestor forfeit the right to reimbursement for the services in dispute?

Findings

1. 28 Texas Administrative Code §133.20(b) states, in pertinent part, that, except as provided in Texas Labor Code §408.0272, "a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided. In accordance with subsection (c) of the statute, the health care provider shall submit the medical bill to the correct workers' compensation insurance carrier not later than the 95th day after the date the health care provider is notified of the health care provider's erroneous submission of the medical bill. A health care provider who submits a medical bill to the correct workers' compensation insurance carrier shall include a copy of the original medical bill submitted, a copy of the explanation of benefits (EOB) if available, and sufficient documentation to support why one or more of the exceptions for untimely submission of a medical bill under §408.0272 should be applied..." Review of the documentation submitted by the requestor finds that no convincing documentation was found to support that any of the exceptions described in Texas Labor Code §408.0272 apply to the services in this dispute, nor that the bills were submitted timely. For that reason, the requestor in this dispute was required to submit the medical bill not later than 95 days after the date the disputed services were provided.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	October 17, 2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received

by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.